PRINTED: 01/14/2019 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING IL6010342 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2001 CEDAR STREET APERION CARE CAIRO** CAIRO, IL 62914 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation 1857139/IL106992 -F580, F584, F686, F712 are cited. Complaint Investigation 1857166/IL107062 - No deficiencies are cited. Complaint Investigation 1857290/IL107160 - No. deficiencies are cited. A partial extended survey was conducted - F712, F727, F773, F838 are cited. \$9999 Final Observations \$9999 Statement of Licensure Violations: 300.610a) 300.1210b)d)2)3)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

and dated minutes of the meeting.

policies shall comply with the Act and this Part.

The written policies shall be followed in operating the facility and shall be reviewed at least annually

by this committee, documented by written, signed

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE 12/31/18

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without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent

new pressure sores from developing.

Section 300.3240 Abuse and Neglect

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C IL6010342 B. WING 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2001 CEDAR STREET APERION CARE CAIRO CAIRO. IL 62914** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET **EVIDENCED BY:** Based on observation, interviews, and record review, the facility failed to recognize the development of pressure ulcers, initiate, and implement measures to promote healing, accurately document the correct location. description, and progress of these pressure ulcers, report a decline to the physician, and seek timely medical treatment for 2 (R3 and R7) of 3 residents reviewed for pressure ulcers in a sample of 8. The facility also failed to follow their policy and notify resident's family and/or representative, and primary physician when there was a significant change in the resident's condition for 1 (R3). The facility also failed to ensure timely physician visits for (R3 and R7), resulted in R2 to undergo an emergency right through the knee "guillotine" amputation on 10/18/2018 with a subsequent above the knee amputation and closure of the surgical site on 10/22/2018. The Braden Scale for Predicting Pressure Sore Risk Assessments reviewed, documented all 73 residents residing in the facility are at risk for skin breakdown. V3 (Regional Nurse Consultant) verified in an interview on 11/28/18 at 1:00 pm, all 73 residents residing in the facility are at risk for skin breakdown. Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	admitted to this faci following diagnoses chronic obstructive malignant neoplasm essential hypertens protein-calorie malidocumentation of prontributing underly admission. Review of R3's clini (family member) is R3's medical care. According to R3's Maracking record date	Report documents R3 was lity on 07/09/18 with the in part - muscle weakness, pulmonary disease (COPD), not colon, colostomy status, ion, and unspecified severe nutrition. There is no ressure wounds or a ring condition upon R3's cal record documents V21 POA (Power of Attorney) over dinimum Data Set (MDS) entry at 07/09/18, R3 has no				
	documentation of R until a Skilled Chart PM documents a ne	wever, is at risk. There is no 3 having a pressure wound ing note on 07/26/18 at 1:55 ew skin concern of " right thas treatable wounds". entation of physician nent initiation found.		2		
	no further documen the heel on this date	entation of physician nent initiation found. There is tation of a pressure wound on e or any other date prior to R3 espital on 08/01/18 (nurses				
	physician's visit or p during R3's stay at t R3's Admission Ass documents a Brief I	entation in R3's record of any ohysician progress notes the facility. essment on 07/16/18 nterview for Mental Status ng moderate cognitive				

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(X3) DATE SURVEY COMPLETED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

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\$9999		ervation dated 07/09/18 moderate risk for skin	S9999		
	document R3 prese wounds: Wound but buttocks left suspect buttocks sacrum Sta suspected deep tiss	ssion records dated 08/01/18 Inted with the following Itocks right Stage III; Wound Ited deep tissue injury; Wound III; Wound coccyx III; Wound heel right I ankle right suspected deep			
	08/07/18 at 11:05 A discharged back to Wound buttocks right Wound sacrum right surrounding tissue right; Wound a	I care reporting dated M documents R3 is being facility with the following: ht; Wound buttocks left; t; Wound coccyx - ed - dressing foam. Wound nkle right - site black - clean, dry and intact - open to			
	dated 08/07/18 at 2: returned to the facili Stage II wound to bi eschar to right heel. documentation of th	e other pressure areas and care reporting document			
pois Deserv	in a Skilled Evaluation 9:29 PM indicating Franchissue is painful notes dated 09/20/1 09/26/18 document has an odor, and tis	ht heel were first documented on note dated 09/15/18 at R3's right heel has an odor . R3's Skilled Evaluation 8, 09/22/18, 09/25/18, and R3's right ankle/heel wound sue remains painful and no documentation that V15			

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ointment 250 U/mg (units per milligram), apply to right heel topically two times a day for area of

An Orders-Admission note dated 08/10/18 at 8:23

The facility was unable to provide reproducible evidence of when R3's Santyl was received from

PM documents, "Santyl not sent from rx

eschar. "No Santyl in yet."

the pharmacy and initiated.

(prescription) yet."

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he came to the nursing home 3 months ago so the initial history of the ulcer is unknown.

physical exam includes a skin inspection documenting decreased turgor, right foot

However they are saying it got worse lately." R3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010342		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE COMP	SURVEY	
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S9999	foot with bluish skir dry gangrene with skin on the right low with ischemic limp and infection." At the doctor is transferred due to his need for and as soon as postocumentation in Finecrotic right big to present. On 10/18/18 at 1:3 emergency room differency." R3 with surgical intervention facility on this same transfer are - Ganghospital operative in documents a right amputation was performed to the formal of the formal for	on the heel and sole of the of toes. Foul smell, mostly some fluctuation. Pale, shiny wer leg." "Findings consistent (sic) with advanced gangrene his time, V26 (local wound R3 to a higher level of care intravenous (IV) antibiotics sible amputation. There is no R3's record indicating a e and middle toe wound is 7 PM, R3's local hospital isposition records document, represent a certified medical as transferred at this time for n in a higher level of care e date. R3's diagnoses upon grene and Sepsis. R3's local report dated 10/18/18 through the knee guillotine reformed on this date. 1 PM a nurse's note for R3 at (pt) taken to wound clinic and him taken to emergency				
		one of his patients so he never V14 stated someone from the				

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On 11/08/18 at 9:00 AM, V2 (Director of Nursing/Wound Nurse - DON) confirmed in an interview V15 (R3's primary care physician) never

saw R3 in the facility or in his local office.

On 11/08/18 at 11:00 AM, V26 (Wound physician) states the first time he saw R3 was on 10/18/18, and was in bad shape when he arrived. The condition of R3's toes would typically take a long time to develop, and his foot condition did not develop overnight. V26 states he is not aware of R3's history, but can say he would have stood a

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
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\$9999	above knee amputa aggressively with IV Discharge Summal under Final Diagnolower limb due to a 10/20/18); Ulcer of An Occupational TI 10/22/18 from this R3 was living at ho fell and had hip painursing home 2-3 recome non-ambupressure ulcers and extremity (RLE). R3's local hospital 10/18/18 document guillotine amputation V30 (Vascular Surgoffered to the patier room for urgent thronight. Benefits, recomplication, include heart attack, stroke with the patient. Allimit to, comfort carsecond opinion with etc. were offered to understanding and proposed surgery in On 11/08/18 at 9:00 Nursing/Wound Nuinterview there is no record of a physicial record of a phys	ation (AKA). He was treated / antibiotic therapy." ry dated 10/26/18 documents ses in part - Gangrene of right therosclerosis (resolved right foot (resolved 10/19/18). The part - Gangrene of right therosclerosis (resolved 10/19/18). The part - Waluation note dated same local hospital documents me in a senior apartment. He in and was transferred to a months ago for rehab. He then latory resulting in multiple digangrene of right lower Toperative report dated the aright through the knee on was performed on this date, geon) documents in part - "I not to take him to the operating ough the knee amputation isks, and potential ding but not limited to, death, thewere discussed at length ternative, including but not re measures - hospice care, in a different vascular surgeon, to the patient. He voiced wanted to proceed with the	S9999	DEPICIENCY		
		43 AM, V21 (family member)				

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arrived to work on the morning of 11/08/18, V20 (RN) was observed cleaning R7's pressure area wound on the right buttock. V20 (RN) removed her gloves, put on clean gloves, and then put a black sponge dressing inside R7's pressure area

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APERION	N CARE CAIRO	2001 CED CAIRO, IL	AR STREET 62914			
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 wound. V20 (RN) then took her gloves off and used scissors to cut a small notch in the top of the black sponge in R7's wound. V20 then put on clean gloves and applied a clear dressing to R7's wound. V20 removed her gloves and applied a second clear dressing to R7's wound. After providing this care to R7, V20 (RN) then left the room, and went to the nurse's station, went through the treatment cart for more supplies to continue the wound treatment for R7. V20 returned to R7's room and applied a clear dressing to R7's wound and then applied the wound vac. V20 (RN) did not wash her hands prior to exiting the room, touching and removing treatment supplies from the treatment cart. Upon returning to R7's room, V20 (RN) did not wash her hands prior to continuing R7's wound care, and completing R7's dressing change. V20 (RN) did not continuously wear gloves throughout the wound care observation and was observed touching the black sponge while it was inside the wound, touching the surrounding tissue, and touching the clean dressing without		S9999			
	wound treatment re treatment to R7's le be an order for trea (DON) and this sur posterior thigh to e was wound/pressu during this observa area to the left pos confirmed she was wound/pressure ar	ea on R7's left posterior thigh				
		ation with the surveyor and mentation in R7's record				

related to the wound/pressure area on R7's left posterior thigh. Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		IL6010342	B, WING		C 11/28/2018		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
APERIO	N CARE CAIRO	2001 CED CAIRO, IL	AR STREET 62914				
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROFILE (EACH CORRECTION SHOULD BE FIGURE OF THE APPROPROPROFILE (EACH CORRECTION CORRECTIO			(X5) COMPLETE DATE	
S9999	Continued From pa	ge 14	S9999				
	On 11/09/18 at 2:0-DON) stated she was gloves whe or surrounding tissuafter wound care be touching other wous confirmed R7's wou continuously. V2 stago to dialysis if the stated if R7 refused dialysis it should be returns to the facility R7's Braden Obserdocuments a score moderate risk of sk 2:00 PM, when aske	O PM V2 (Director of Nurses would expect the nursing staff in touching wounds, dressings, ue, and to wash their hands efore leaving the room and/or and care supplies. V2 (DON) and vac is to be in place ated sometimes R7 refuses to wound vac is left in place. V2 I to wear the wound vac to put back on as soon as she y from dialysis. Vation dated 11/06/17 of 13 which indicates R7 is at in breakdown. On 11/09/18 at ed where R7's quarterly ts were, V2 (DON) stated she e any other Braden					
	documents a focus chronic pressure ule a Stage 3 pressure and on 10/26/18 and on R7's right buttoct on R7's left buttock. R7's care plan documents are treatment for R7's left buttock, left 10/26/18. R7's treat treatment for R7's left orders documented coccyx. R7's wound consistent measure wound on R7's coccimeasurements/asset	ements a stage 3 wound on left buttock, and coccyx on lement record documents a left buttock with no treatment for R7's right buttock or logs do not document lements/assessments for a		9			

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED. C B. WING IL6010342 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2001 CEDAR STREET APERION CARE CAIRO CAIRO, IL 62914** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 15 S9999 showed a wound to R7's right buttock and a new area to R7's left posterior thigh. The facility documentation is unclear where R7's wounds are and what treatment R7 is receiving for what wound. The facility pressure ulcers/wounds log documents R7 has a stage IV wound on her right buttock with the following measurements: 9/10/18 - 7.1 x 6.1, 10/02/18 - 5.8 x 3.1 x 0.6, 10/15/18 -5.8 x 3.0 x 0.5, 10/29/18 - 7 x 9 x 5, and 11/5/18 -6 x 8.5 x 4.5. R7's wound log did not document measurements on 9/17, 9/24, 10/08 and 10/22/18. R7's wound log does not document measurements, staging, or assessment of a pressure area on the left buttock. R7's wound log documents a stage 3 pressure area on R7's coccvx measuring 9 x12 on 8/27/18 and 8.5 x 11.75 on 9/4/18. There is no other documentation related to a pressure area on R7's coccyx after 9/4/18. R7's treatment records document the following physician orders for treatments to R7's pressure areas. R7's 9/1/18-9/30/18 Treatment Administration Record (TAR) documents an order for a foam dressing pad to be applied to R7's left posterior thigh once daily and for a solution to be applied to R7's coccyx topically twice daily with a wet to dry dressing. R7's 10/01/2018-10/31/18 TAR documents a physician order for foam dressing pad to be applied to R7's left posterior thigh daily and for a solution to be applied to R7's coccyx with a wet to dry dressing twice daily. R7's 11/01/18 -11/30/18 TAR documents a

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING IL6010342 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2001 CEDAR STREET APERION CARE CAIRO** CAIRO, IL 62914 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 16 S9999 physician order for foam dressing pad to be applied to R7's left posterior thigh daily. R7's 11/2018 treatment administration record documents the foam dressing to R7's left posterior thigh was not in place on 11/07/2018. R7's regional wound clinic note dated 10/31/18 continues to document under assessment notes. "Pt (patient-R7) states the nursing home applied wound vac but "it kept beeping" so they "took it off." R7's weekly skin observations do not document measurements, descriptions of pressure areas. or staging on 9/7, 9/14, 9/21, 10/05, 10/12, 10/19. 10/26, 10/30 and 11/02. R7's weekly skin observations document on 11/02, "pressure ulcer right buttock, wound vac in place" and on 9/21/18 "deep wound ...coccyx ...wound clinic newly caring for R7's wound." R7's nurses notes reviewed from 8/6/18 through 10/30/18 do not consistently document stages, measurements, and/or assessments of R7's pressure areas. The facility pressure injury and skin condition assessment policy dated 1/17/18 documents. "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and documented in the resident's clinical record

PRINTED: 01/14/2019 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6010342 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2001 CEDAR STREET APERION CARE CAIRO CAIRO. IL 62914** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 17 S9999 1. A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. 2. Residents identified will have a weekly skin assessment by a licensed nurse. 3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse. 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. 5. If the resident receives a shower, it will be necessary to have the resident stand or be returned to bed to visualize the buttock area and 6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. 7. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes. 8. Prior to performing the skin assessment, the nurse is to have a sufficient supply of clean disposable gloves to perform assessments on multiple areas. Conduct hand washing in accordance with facility standard/universal

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precautions.

9. A disposable measuring device (one time use) will be used to measure dimensions, and if necessary, a clean cotton tipped applicator to measure wound depth/tunneling/undermining. 10. Pressure injuries and other ulcers (arterial. diabetic, venous) will be measured at least

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6010342 11/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2001 CEDAR STREET **APERION CARE CAIRO CAIRO, IL 62914** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 18 S9999 weekly and recorded in centimeters in the resident's clinical record. 11. A wound assessment for each identified open area will be completed and will include: a. Site location b. Size (length x width x depth) c. Stage of pressure ulcer d. Odor e. Drainage f. Description g. Date and initials of the individual performing the assessment 12. Measure length vertically in relation to head to toe position. Measure width horizontally in relation to hip to hip. Measure depth straight down into the deepest part of the wound. *If the wound is necrotic and the base of the wound hed is not visible or tunneling, the stage cannot be measured and must be recorded as non-stageable with a undetermined depth. 13. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. Physician and responsible party notification will be documented in the clinical record. These changes include, but are not limited to: a. New onset of purulent drainage b. New onset of odor c. Cellulitis d. Increased pain related to wound e. Significant increase in wound measurements f. Onset of new ulcers 14. Dressings which are applied to pressure ulcers, skin tears, wounds, lesions or incisions shall include the date of the licensed nurse who performed the procedure. Dressing will be checked daily for placement, cleanliness, and

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